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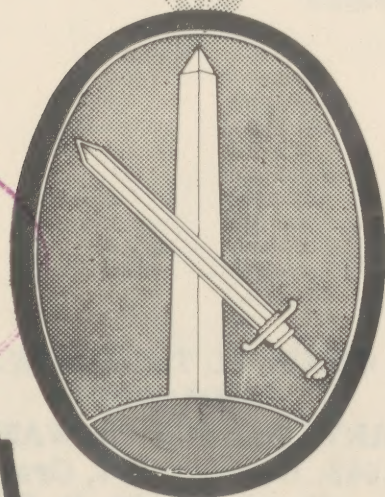
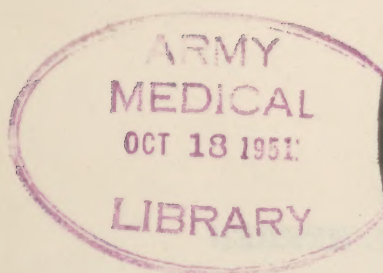
RESTRICTED

MONTHLY

HEALTH

REPORT

Military District of Washington



RESTRICTED

AUGUST 1951





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MAJOR GENERAL THOMAS W. HERREN  
COMMANDING  
MILITARY DISTRICT OF WASHINGTON  
Room 1543, Building T-7, Gravelly Point  
Washington 25, D. C.



## INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

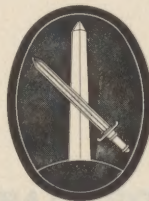
Contributions, as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

ROBERT E. BITNER  
Colonel, MC  
Surgeon



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# PREVENTIVE MEDICINE

## CANCERPHOBIAS

By  
Captain Leslie Upton, M.C.  
US Army Dispensary, The Pentagon

The campaign to blot out cancer in the United States has attracted nation-wide attention. The original idea to eradicate cancer, is a good one. Linked with the teaching of an annual physical examination, carefully done, and with necessary references to specialty clinics, much gain to the American people can be accumulated. However, it is felt that the intensive propaganda in the name of cancer is causing an epidemic of psychoneurosis characterized by anxieties, both temporary and permanent.

Are the advertising techniques used in the fight against cancer creating "cancerphobias" in too many individuals? Some physicians feel so. That is the opinion of the writer who has seen a number of patients "who just know they have cancer." These people live each hour in dreadful fear of it, although extensive physical examination is negative. Negative, I repeat, except for this phobia.

Cancer research has taken great strides in recent years--thanks to many public spirited individuals, who have given of their time and money. The work must go on, much more money from the American people and much more time of the devoted research workers will be needed before the answers to the cancer problem will be uncovered. As yet there is no simple test, although there are many diagnostic procedures. Some of the things that must be watched are:

- (1) A lump anywhere in the body that does not disappear in a few days.
- (2) A skin irritation or ulceration which does not heal.
- (3) Rectal or vaginal bleeding.
- (4) Inability to eat regularly; accompanied by pain in the abdomen and loss of weight, especially in persons over 40.
- (5) Chronic cough, which changes in character and intensity and is accompanied by bloody sputum.
- (6) Constipation alternating with diarrhea.

This is a plea for less emotional campaign advertising which I feel is doing harm to our people. It is not a plea to stop contributions which we all know are needed to carry on this great work in ferreting out the causes of cancer, discovering new methods, and bringing to the people the need for regular physical examinations.

\* \* \* \* \*

## POST-INFECTIOUS STATE

By  
M. E. Groover, Jr.

The article "Post-Infectious State", published in the March 1951 issue of the EUCOM Medical Bulletin is abstracted below.

In 1945 at the rheumatic fever center in Jackson, Mississippi, the author became interested in a group of patients who exhibited no definite signs of rheumatic disease. The patients were not well; attempts to give them graded exercise uniformly met with no success. After months in the hospital they were discharged and told to report to a veteran's hospital if they did not improve at home. We all talked about a thing called "Hospitalitis" and explained to the patient that he could not get well till he left the hospital and started to work at some interesting, gainful occupation. No one considered this disposition entirely satisfactory; however, it was the best we know.



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Here the same type of patient (is) encountered. Usually they were originally admitted with an acute upper respiratory or flue-like syndrome. After all physical signs and laboratory examinations became normal, they were discharged to full duty with their outfit. After several days to two weeks, they returned to the hospital with the most bizarre set of vague symptoms one could imagine: Fatigue, vague joint pains, nervousness, lethargy, epigastric distress, mild frontal headaches, dizziness, and an endless list of other complaints.

We made a special search for emotional conflict that could be used in making a psychosomatic diagnosis and found it in every case. However, none of us were entirely satisfied with the psychosomatic angle. The response to exercise was typical of that group of patients once called neuro-circulatory asthenia: Sweating, tachycardia, hypotension.

A more careful evaluation revealed many of them to have minor EKG changes; a positive cephalin flocculation test, and a relative increase in the lymphocyte count; a mild tachycardia on slight exertion, and a blood pressure ranging around 100/60.

It was first thought that a physical reconditioning program would be the answer to the problem. A German physical education instructor was employed and the patients were started on a program of graded exercises. We soon learned that those patients with a positive cephalin flocculation test responded poorly to exercise. The physical education instructor was taught to take pulse and blood pressure readings before and after the exercise period. Patients showing an abnormal response to exercise were placed on strict bed-rest with bathroom privileges only. About this time one of the doctors noticed that the serum albumin of this group was slightly below the average normal for this laboratory. As a result of this observation, all such patients were given supplemental feedings of powdered skim milk daily. An attempt was made to give 300 grams per day, but it was difficult to make many of them take such a dose and strict supervision was necessary. Because of positive cephalin cholesterol flocculation test was considered to be evidence of mild chronic liver damage, dried brewer's yeast tablets were added to the diet, 5 grams three times a day.

The patients were kept in bed until their cephalin flocculation test became negative then started on a graduated exercise program. Alternate cases were selected as controls, and ten cases were treated with bed-rest and hospital regular diet. The controls were ready to start exercise in an average of 46 days, while thirty cases given the yeast and milk supplement started their exercise in an average 29 days.

Most of these patients have the following complaints:

- (a) History of acute upper respiratory infection with or without signs of atypical pneumonitis.
- (b) Severe fatigue noticed 7-21 days after recovery. Forced exercise produces sweating tachycardia. Feeling of exhaustion. Dizziness.
- (c) Women have scanty irregular menstrual flow with sexual anorexia. Men complain of loss of libido and memory defect and inability to concentrate.
- (d) Terrible hangovers.
- (e) Chronic nasal congestion.
- (f) Arthralgia especially in the mornings on getting out of bed. Low back pain.
- (g) Weight loss if the condition has existed long.
- (h) Irritability.

Physical examination is usually negative except for the following:

- (a) Blood pressure a low normal 95/50 to 110/60.
- (b) Poor muscle tone with increased lumbar lordosis.



## PREVENTIVE MEDICINE

- (c) Poor cardiac response to exercise.

Laboratory findings are consistent in that:

- (a) The differential count shows a lymphocyte count almost always above 35 percent, usually above 40 percent, with no consistent increase in eosinophiles.
- (b) The heterophile antibody agglutination is always in low titer or negative.
- (c) The cephalin cholesterol flocculation test is positive.  
1 + or 2 + in 24 hours and 2 + to 3 + in 48 hours.
- (d) The thymol turbidity is positive for 2 to 6 units in all cases, only four out of a series of 21 cases gave a thymol turbidity of more than 4 units.
- (e) The hemoglobin and hematocrit is usually slightly above the accepted normal.

Clinical Management: (a) Special handling, patient often is irritable, comes to see the doctor with chip on his shoulder. (b) Careful history. (c) Complete physical examination plus laboratory work. (d) Explain the nature of the illness. (e) Bed-rest till cephalin flocculation is negative. (f) B complex brewer's yeast. (g) Powdered skim milk. (h) Graduated exercise when cephalin flocculation is negative. Require patient to keep diary of progress in exercise program.

Why the combination of brewer's yeast, powdered skim milk, with bed rest produces improvement in these patients, I have not the slightest idea. This condition is not new. The treatment of bed-rest and brewer's yeast was frequently used by our family doctor in 1919 and 1920. A controlled series of cases are being followed in the OPD of this hospital, at the present time. In 12 months the relative value of the three elements, bed-rest, brewer's yeast and powdered skim milk, in comparison to no treatment at all should be determined.

### REARWARD-FACING AIR TRANSPORT SAFETY SEATS

The first MATS aircraft to be fitted with new rearward-facing safety seats has recently been put into service. The plane, a C-97A, is the first of many that will have this high "G" stressed equipment installed. In 1947, a traffic survey in the former Air Transport Command revealed that the majority of passengers questioned preferred to travel facing the rear of the aircraft rather than toward the front. Deceleration studies later made proved that the maximum safety could be obtained if the passenger was supported in a seat that faced the rear. Development of such a seat was immediately begun at the Engineering Division of the Air Materiel Command. The seat finally decided on, and currently being manufactured by the Beechcraft Corporation, is stressed for 16 "G's" based on 250 pound load. It is well contoured to the body and padded with foam rubber covered with a nylon plastic material. The foam rubber compensates for anthropological deviations from the overall human average measurements which were used when the equipment was designed. Incorporated in the seat for additional comfort is a built-in foot rest. The value of this type of equipment has been decidedly proven in two recent crashes of foreign aircraft which had just been equipped with rearward-facing seats. In these crashes, no passengers received fatal injuries and investigation revealed that their lives were saved due to the seating arrangement. Those being service tested are double seats -- two passengers sitting side by side. To obtain the desired safety limits, the floor fittings and floor were strengthened and modified to withstand the maximum 16 "G" stress.

(The above article is from MATS Andrews Air Force Base, Letter of Information(Medical) No. 84, dated 25 June 1951)



## PREVENTIVE MEDICINE

### IMPROVED METHODS OF TREATING FROSTBITE RECOMMENDED BY ARMY MILITARY AND CIVILIAN EXPERTS

A team of military and civilian experts who spent a month in Japan and Korea studying frostbite cases have recommended improved methods of treating this type of injury, the Department of the Army announced today.

Principal methods suggested for treating frostbite include rest in bed and no smoking for all patients, daily foot care with a mild, non-irritating cleansing agent, a hospital ward temperature maintained between 72 and 78 degrees, the use of penicillin during evacuation for treatment and employment of other antibiotics during treatment, and the delay of surgery until there is no question of demarcation of the affected part.

The team's recommendations, arrived at after consultation with the National Research Council's subcommittee on vascular surgery, alters only slightly the Army's present plan of treatment for frostbite cases.

Although research in cold injuries has been in progress for some time, a program designed to coordinate civilian and military research in this field is now nearing completion, guided by the Medical Research and Development Board, Office of the Army Surgeon General, and the National Research Council.

Studies in rapid thawing of the frozen part, regional and general dilatation of blood vessels, anticoagulants, and abstinence from tobacco will be carried out at the Army Medical Research Laboratory at Fort Knox, Kentucky.

A post-frostbite condition called "cold foot syndrome" will be among the important studies made at Fort Knox. This condition frequently develops three to six weeks after the initial cold injury and is characterized by cold feet, excessive sweating and vague sensory disturbances.

Forty frostbite patients from Korea who are experiencing "cold foot syndrome" will be transferred to Fort Knox in July from the Far East Command's cold injury treatment center at the Osaka, Japan, Army Hospital. This group of patients will be studied throughout the summer to determine the nature of this process and the best methods of treatment.

The team of Army military and civilian experts who studied frostbite cases in Japan and Korea included Dr. Carl W. Gottschalk of Boston, Massachusetts; Dr. John H. Talbott of Buffalo, New York; Colonel Charles B. Henry, MC, of Army Field Forces Headquarters, Fort Monroe, Virginia; Lieutenant Colonel Joseph R. Blair, MC, and Second Lieutenant Ernest R. Kolovos, MC, both of the Army Medical Research Laboratory at Fort Knox, Kentucky, and Captain Emanuel M. Fainer, MC, assigned to the hospital at Osaka.

(The above article is from Technical Information Office, Office of the Surgeon General, Department of the Army, Washington 25, D. C.)

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#### GOOD PUBLIC RELATIONS

In the Surgeon's Section of the Military District of Washington, a standard operating procedure of mailing a post card, DA Form 209, to each claimant for reimbursement for medical service rendered upon WD AGO Form 8-9, has been adopted. Whenever a voucher is received in this section, the interested parties are notified by the use of a post card that the claim has been received, and that it is estimated that so many days will be required in the processing of the claim. Also, when it is necessary to forward this claim to another army area, the claimant is notified as to what headquarters the claim has been referred. It is felt by adopting this system hospitals, civilian doctors and dentists are kept informed as to the status of their bills. The feeling of institutions, not desiring to render treatment to military personnel due to the large amount of time lag in processing of the claim and the long period of time before the claim is actually paid will, by the sending of this notice of information, aid in reducing such feeling. Although the sending of such a post card is not required by regulations, it has been the experience of this section that fewer complaints as to the delay in processing have been received since the instigating of this system.



# PREVENTIVE MEDICINE

## NEUROPSYCHIATRIC CONDITIONS IN KOREA, DECEMBER 1950-MARCH 1951

Although a rise in the incidence of neuropsychiatric conditions among Army troops in Korea accompanied the increased tactical activity during the winter months, the rate never approached the magnitude of those reported during the heavy fighting that took place in August and September 1950. From a low of 18 reported during the October lull in combat operations, the rate rose steadily during each of the ensuing four months, then declined slightly in March 1951. The highest rate attained during this period was 71 in February; this was considerably lower than the rates reported during August and September 1950, which were 250 and 177 respectively.

The comparative lowness of the neuropsychiatric rates for Army troops in Korea this past winter despite the prevailing adverse tactical and climatic conditions, probably stems from the fact that the troops engaged were by then more seasoned and battle-conditioned and because until late in January the fighting was of a defensive nature. It is remarkable that the lowest rate reported during the winter season, 48, occurred during December, the month of the hectic forced withdrawal from North Korea in sub-zero weather. Moreover, the proportion of neuropsychiatric cases to battle injuring and wound casualties in Korea during December was no higher than it had been during the preceding five-month period, which was approximately 1 to 6. (This ratio is about the same as experienced in World War II by troops of the Fifth Army in Italy in the Mediterranean Theater of Operations from September 1943 through December 1944, a period which included such major actions as Cassino, Anzio, Garigliano, and the Gothic line.)

As the table below shows, the ratio fluctuated during the winter season. The sharp rise in the ratio of neuropsychiatric cases to battle casualties during January was due largely to the low battle injury and wound rate in that month (98) rather than to any marked increase in the incidence of neuropsychiatric conditions. In part however, this rise in the number of neuropsychiatric cases as compared with the number of battle injuries and wounds in January probably was caused by the combination of emotional stress and physical fatigue experienced by the battle-weary troops during the unfavorable tactical situation that existed, particularly during the early weeks of the month. Observers during the World War II campaigns in North Africa and the Mediterranean found that a progressively disproportionate increase occurred in the number of psychiatric cases as compared with the number of wounded when units remained in contact with the enemy over long periods. This increase occurred during all degrees of combat activity, during both defensive and offensive operations. It is of interest to note that, according to field reports, an increasing number of the neuropsychiatric cases reported during January and February 1951 were admitted from replacement battalions. Also, many of the "combat exhaustion" cases admitted to medical facilities during these months had been in combat from 90 to 120 days.

COMPARISON OF NEUROPSYCHIATRIC AND BATTLE CASUALTY ADMISSION RATES  
United States Army Troops in Korea, July 1950-March 1951

Month	Admission Rates a/		Number of NP Admissions to 100 BC Admissions
	Neuro- psychiatric Conditions	Battle Injury and Wound	
Total	71	345	20.6
July	49	588	8.3
August	250	982	25.5
September	177	1187	14.9
October	18	157	11.5
November	29	163	17.8
December	48	269	17.8
January	63	98	64.3
February	71	361	19.7
March	59	188	31.4

a/ Rates expressed as admissions per thousand mean strength per year. Minor differences from previously published rates result from incorporation of data from corrected report.

(The above article is extracted Disease and Injury, "HEALTH OF THE ARMY" ARMY PROGRESS REPORT, APR 51)



# PREVENTIVE MEDICINE

## FIELD HOSPITAL NEUROPSYCHIATRIC SERVICE

The Neuropsychiatric Service of the 4th Field Hospital served as the main psychiatric treatment center for UN Forces in Korea during the months of November and December 1950, and for this reason a somewhat detailed report is herein presented. When first organized, the service had one psychiatrist. It soon became apparent that one man could not handle the volume of work and an additional psychiatrist was assigned. The wards of the Psychiatric Service were separate from the Medical and Surgical wards. This was felt to be necessary due to the so-called infectiousness of some psychologic symptoms. Beds used were army cots and patients made their own beds, usually. Food was not served on the ward, all patients having been encouraged to go to the mess hall for meals.

### Types of Cases seen:

It soon became apparent that the types of cases differed somewhat while troops were engaged in active combat and while there was a break in activity. During combat with the enemy there was an upswing in the number of moderate and severe anxiety reactions and in conversion reactions, while in the periods between combat there were slight decreases in the number of anxiety and conversion reactions. In their places other neurotic reactions, psychotic reactions, character disorders, and immaturity reactions were seen. The overall picture included approximately 70% neurotic reactions, 10% psychotic reactions, 12% character disorders and immaturity reactions, 2.5% neurological diseases, and 5.5% no disease found (including very poorly motivated soldiers and normal combat reactions as described by Ranson). The average daily admissions varied considerably depending on numerous factors, including the tactical situation of the day, availability of transportation from the front, number of surgical casualties who had to be evacuated first and availability of holding beds for the Division Psychiatrists at clearing stations. In general there were 1-30 admissions daily, the usual number being 15-20. During the latter part of November when Chinese forces began an all-out push, the number of admissions on several days was between 50 and 90. It was noted that usually there was a 2-5 day lag between the time surgical casualties began to arrive and the time psychiatric casualties began to arrive during active combat. Anxiety reactions were by far, the most frequent entities seen, with conversion reactions next in frequency.

It was soon learned that the symptomatology of the anxiety reaction was of little importance; it varied from patient to patient, but almost universally the conflict was very close to, if not at the level of consciousness. This conflict seemed always to involve directly the combat situations and the dangers to the individual inherent to this situation. As will be mentioned below under the discussions of interviews and therapy, the therapist could quickly "peel away" the symptom layer, and could discuss directly with the patient the conflict of which the patient was at least partly aware. In some perfectionistic, compulsive individuals defenses would quickly break down under the conditions of battle which did not lead themselves to perfectionism, and these individuals would then develop a tremendous amount of anxiety. But in general the anxiety reaction was seen in individuals who were not of necessity compulsive, and who had been exposed to a considerable amount of combat. The backgrounds and family life of these individuals varied considerably and we can report nothing conclusive in regard to this at this time although we are attempting to study this.

The severe anxiety reaction was usually found in an individual who had considerable combat in this campaign (and sometimes in World War II as well). He would usually come in looking markedly fatigued with face drawn and expressionless or full of terror. Tremulousness, voice difficulty, dilated pupils, rapid pulse, profuse sweating tremors, and sometimes tearfulness were seen. The subjective complaints usually included insomnia, anorexia, more than the usual weight loss, battle dreams (which seemed always to be attempted at mastery of a situation in which the individual felt he had failed). Usually there is an immediate precipitating factor which assumes great importance in such individuals, such as the death of a friend with whom he has gone through numerous fire fights, or the inability to remove one of the wounded of his platoon while under fire. Usually the neurotic symptoms do not appear till after the individual is removed from danger. This protective mechanism has been noted in the other psychiatric syndromes as well.

The less severe anxiety reactions are somewhat similar in symptomatology, but symptoms are not severe and frequently the individual has just gone into combat for the first time although he may have been in Korea for some time previously.



## PREVENTIVE MEDICINE

### Types of Interviews and Treatment:

Each patient was seen on his first hospital day and each day of hospitalization by his own psychiatrist. Once the veneer of symptomatology was removed one could discuss with the patient his actual fears of combat, anger at a superior or feeling of inability to do a job for which he may not have been too well suited. Great emphasis was placed in this form of brief, directive psychotherapy upon the current situation rather than upon an often unreliable past history (which patients frequently exaggerated to make it appear that they had a lifelong neurosis). This type of therapy, drawing forth the feelings of the patient in relation to current events, was carried on the following day or two of hospitalization. With this treatment, anxiety frequently lessened or disappeared as the patient began to understand what he was really concerned about. This therapy was effective at this level because rapid evacuation inhibited a complete establishment of the neurosis. The conversion reactions were treated by means of strong suggestion, of abreaction usually under amytal narcosynthesis. Coramine in large doses was used to a great extent following amytal, in an attempt to have the patient wake rapidly following the abreaction. We were not overly impressed with the use of coramine over the non-use of coramine. Almost all conversion reactions became asymptomatic under this form of treatment and most could at least be returned to non-combat duty if not combat duty. It was interesting to note that when the defense of conversion was removed thus, almost all patients, rather than becoming gratified at being able to walk or see, would become extremely hostile toward the therapist. This would usually pass off before the patient returned to duty or would at least become lessened. Included in treatment was a routine insistence on cleaning up, shaving, and eating within the first 6 to 12 hours. With severe anxiety reactions and psychotics, amytal sedation was used the first night starting with 6 grains and with repeat amounts until enough had been given to insure restful sleep. (In general, sedation was used sparingly and was never routinely ordered.) Frequently a moderate anxiety reaction looked much improved after the patient merely cleaned up and had a good night of sleep. Brief outpatient psychotherapy was attempted with several patients from base units. The accentuation in interview and therapy was always on the current situation in combat and what was happening in the interpersonal relationship between patient and doctor. The patient was not allowed to use the cloak of symptoms without exploration of the conflict. We are much encouraged by our results using this form of psychotherapy.

(The above article is The Surgeon's Circular Letter, Medical Section, GHQ, Far East Command, 1 Mar 51)

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### DETERMINING AND RECORDING OF BLOOD GROUPS OF ALL MILITARY PERSONNEL

The blood group of each individual on active duty in the Army will be determined, using the International (or Landsteiner) classification. The results will be recorded, using the symbols "A", "B", "AB" or "O" as indicated. The accomplishment of the blood grouping in each organization is the responsibility of the commanding officer. The surgeon is responsible for the proper performance of the test and he will insure that personnel performing this test are properly trained and properly supervised. Individuals processed through reception centers, training divisions, or similar organizations will be grouped before transfer to other organizations. Individuals not processed through such organizations ordinarily will be grouped at the initial Army installation or organizations where they report for duty, provided facilities for performing the test are available.

The commanding officer for the medical facility performing blood grouping of an individual will be responsible that the organization issuing the identification tag is informed of the correct blood group of an individual so that it may be properly recorded on the tag.

The blood group of an individual will be entered on the Immunization Register (WD AGO Form 8-117) in accordance with AR 40-215.

(The above article is from AR 40-340, dated 3 May 1951)



# VETERINARY SERVICE

## DISEASES OF ANIMALS IMPORTANT TO MAN IN TIME OF WAR (Concluded)

by  
R. A. Keiser, D.V.M., Ph.D.

DISEASES TRANSMISSIBLE TO MAN THROUGH FOOD PRODUCTS OF ANIMAL ORIGIN. Now let us mention several diseases of lower animals which are capable of direct transmission to man but which are more commonly transmitted to the human family through food products of animal origin. One of the most important of these is brucellosis. This disease, unfortunately, has a widespread distribution in the United States among cattle, to a lesser extent in hogs, and still less in some other species of animals. The U. S. Department of Agriculture, in cooperation with the various states, has for a number of years been very active in a campaign to control and eradicate the disease. The extent of this work may be visualized when I tell you that from July 1, 1934 (when the extensive control program was initiated) to August 31, 1950, nearly one hundred million blood tests of cattle, involving approximately eight and one-half million herds, were made. These tests identified over four million reactors. At the present time there are approximately two and one-half million herds of cattle, representing approximately eighteen and one-half million cattle, under supervision in connection with the control of brucellosis. This work is of tremendous importance in connection with the control of brucellosis in the human family. While, as I have indicated, brucellosis is occasionally transmitted to man through direct contact with infected animals, such mode of infection is ordinarily limited to individuals whose occupations place them in close association with cattle, hogs, or goats. Thus, while brucellosis can be placed in the category of diseases of animals transmissible to man by direct contact the greater hazard to the population generally would be through the food supply, especially if proper safeguards are not provided. In time of war, as will be readily recognized, it is difficult to markedly increase production of milk and dairy products and at the same time maintain controls and supervision on a level of peacetime efficiency and effectiveness.

What has been stated with respect to brucellosis, in general, applies to tuberculosis. The control and eradication of bovine tuberculosis was the object of a great campaign initiated by the United States Department of Agriculture, in cooperation with the several states, back in 1917. As a result of this endeavor, bovine tuberculosis has been reduced to an incidence of less than one-half of one percent in every county in every state of the Union. While perhaps not generally recognized, the accomplishments in the bovine tuberculosis eradication campaign have had a great bearing on the incidence of bovine type of tuberculosis in the human family. War periods can well result in conditions and circumstances which would hazard the efficiency and effectiveness of the anti-tuberculosis control measures among the cattle population of this country.

Another disease of livestock which has become somewhat of a factor with respect to human health is swine erysipelas. This disease has become increasingly prevalent in the United States during more recent years and with it a corresponding increase has been noted in the number of human cases reported. Fortunately, however, the cases occurring in man have not as yet reached sizeable figures. Nevertheless, the disease, while not commonly of serious character, can take on a very serious aspect and even cause death in man. I had brought to my attention during the war a case of swine erysipelas infection in a soldier which was particularly serious. This man was not expected to live but fortunately it was found that penicillin was specific in the treatment of the condition and the patient owed his life to the availability of that antibiotic at that particular time. Under conditions incident to major conflicts the incidence of swine erysipelas may increase and, thereby, produce a greater hazard to man.

Infection of man by various pathogenic organisms of lower animal origin, of course, occurs through the medium of our food supply. This hazard is considerably greater under war conditions than during peacetime. One very important possible avenue of infection which must be closely watched is the milk supply. In World War I the milk supply for the Army did not constitute a very important problem. When we went into that war troops were placed on canned milk, thereby eliminating problems that might have come up had we provided a fresh milk supply. During the period between World War I and World War II, however, fresh fluid milk had become a standard item of ration in the soldier's mess. When we became involved in World War II serious consideration was given to the question as to whether or not we should attempt to continue to supply fresh fluid milk as an item of military ration or go to canned or powdered milk. Because of the possible effect on morale, and also because of the tin shortage, it was decided to do everything possible to continue to supply fresh fluid milk. Before the war was over this item ran into huge figures and posed many difficult



## VETERINARY SERVICE

problems. In the first place, local milk supplies in many areas were insufficient to meet the demands of military camps and stations located in such areas. This was particularly true in certain sections of the South. Under the circumstances, it became necessary to ship milk from localities where there were surpluses to areas which were short. Many problems having a direct sanitary bearing on the milk supply were met with. Pressure was exerted to ease up on the pasteurization required, to permit milk to be supplied in bulk, to eliminate lip-protecting caps on milk bottles, and to let down the bars with respect to sanitary requirements, bacterial counts, and other quality factors concerning raw milk received at pasteurization plants. Fortunately, it was possible to successfully resist many of the attempts to lower or ease up on control and safety factors and we went through World War II with no serious outbreaks of diseases traceable to the milk supply.

Another foodstuff which attained great prominence during World War II was desiccated eggs. Thousands of tons of this food item were produced and utilized during the war. It posed many questions with respect to health, not only with respect to our own soldiers and people, but to the armies and civilian populations of those countries among our allies to whom we furnished desiccated eggs under lend-lease arrangements. It must be realized that the desiccated egg business was essentially a new industry in the United States which grew tremendously as the war progressed. Early methods utilized in producing dried eggs were conducive to bacterial propagation and it was not early known what the disease hazard might be from this product. We found that numerous species of *Salmonella* organisms were frequently present in the eggs and that the drying procedure did not destroy all of these bacteria. As time progressed the situation was improved, largely through better methods of processing this foodstuff, and in consideration of the enormous quantities of desiccated eggs used in many parts of the world the number of cases of disturbed health attributable to powdered eggs was minor.

The war also posed disease problems with brucellosis, typhoid fever, and tuberculosis infection through the medium of cheese ripened for only short periods of time. The ordinary practices in cheese manufacture make it possible for organisms of both animal and human origin to find their way into cheese and if the product is consumed when it is in a relatively green state, organisms of such diseases as brucellosis, typhoid, and tuberculosis may not be destroyed. When the possibility of this hazard was realized early in the war, precautions were taken to insure that cheese for military use was held for a period of time ample to bring about those changes in reaction, etc., which would insure the destruction of disease-producing organisms such as I have indicated. Unfortunately, however, this practice, adopted by the military, was not always carried out when it came to cheese for civilian use and, as some of you may recall, several important outbreaks of brucellosis and typhoid fever followed the consumption of cheese which had been ripened for only brief periods of time.

Canned, cured, pickled, and other forms of preserved meats and other foods of animal origin offer possible hazards of disease or "food poisoning" if proper procedures and precautions in handling and preparation are not followed and observed. In time of war food supplies are more vulnerable to contamination by organisms of both lower animal and human origin because of a possible "let down" in the usual precautionary measures and procedures ordinarily followed in connection with the preparation of canned, cured, or preserved food items. It is, therefore, of great importance in time of war that special attention be paid to supervision and inspection procedures to insure the protection of human health.

ANIMAL DISEASES TRANSMISSIBLE TO MAN WHICH MIGHT BE USED AGAINST US IN BIOLOGICAL WARFARE. As I indicated in the beginning, there are some animal diseases which are transmissible to man and which because of their serious character or their rarity in the human family under normal conditions, would probably be considered by any country proposing to use biological warfare. Time will not permit me, nor is it the intent of this presentation, to go into a full discussion of this subject. I mention it merely to point out this phase of the importance of animal diseases to man in time of war.

The diseases of lower animals which might be considered in this category will, naturally, occur to many of you. Such things as anthrax, glanders, melioidosis, brucellosis, psittacosis, virus encephalitis, plague, tularemia, etc., are some of the diseases which might be thought of.

ANIMAL DISEASES OF IMPORTANCE TO THE FOOD SUPPLY. In all wars of major character the food supply invariably becomes a highly important factor. Anything which affects such supply in a detrimental way immediately presents a serious problem. Of all types of foods, those of animal origin are ordinarily of greatest importance. Animal diseases, therefore, can have a tremendous



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adverse effect on the food supply if they increase in incidence and especially if exotic diseases of serious character are introduced.

I am sure that everyone here realizes the tremendous importance of our food supply, and its production, in the United States during World War II, not only because of the great demands made upon the country for the supply of our own troops and civilians, but also because of the huge requirements of our allies for which they had to depend upon us. It would have been a major catastrophe if the United States had been incapable of meeting the demands. We succeeded only because we were able to control and suppress important animal diseases in this country. This included not only those maladies of food producing animals which were currently present, but also the keeping out of the United States those exotic diseases which would have been of serious consequence had they gained entry and become widespread among our food-producing animals. For example, had a disease such as rinderpest, a virus malady of cattle, made its appearance in this country on a widespread scale it would have given rise to a highly critical situation. This disease has a mortality rate of about 85% to 90% and with our entire cattle population susceptible to the malady we would have counted losses in the millions of animals.

CONCLUSION. In the time available to me I, of course, have been able to cover my subject only in a very general way. I think it will be evident, however, that in time of war animal diseases, like those of man, become of much greater importance than is the case in time of peace. It has oft been said that a war which might be won with bullets can be lost through disease. This is a true statement and the reference to disease might well include the lower animal species, particularly food-producing animals.

(The above is by R. A. Kelser, D.V.M., Ph.D., Professor of Bacteriology and Dean of Faculty, School of Veterinary Medicine, University of Pennsylvania, Philadelphia, Pa.)

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## ADMINISTRATIVE SERVICE

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### SOCIAL WORK OFFICERS IN THE MEDICAL SERVICE CORPS

Social Workers in the Army as officers of the Medical Service Corps are members of the medical team which provides the professional skills needed for the maintenance of a healthy and effective Army.

The Army's social work program is well established. Until recently it has functioned only in relation to psychiatry. Today, however, not only the Army itself but the scope of the social work program is expanding. In addition to their past functions relating to psychiatry, social work officers are now needed to provide case work throughout the wards and clinics of all but the smallest Army hospitals. Consequently, opportunities for commissions in the Army Medical Service for men and women qualified as social workers have increased.

The role of the social work officer has always been important, but it assumes even greater importance today in view of the stresses arising from both combat and rapid expansion at a time when the maintenance of military effectiveness is so vital to the defense of the United States.

#### What Does the Army Social Work Officer Do?

In whatever setting the social work officer is assigned, he will, as a part of his professional social work practice, (1) participate in the intake process; (2) study the patient's background for information about social, economic, and cultural factors which are essential for understanding the person and his problems; (3) contribute to the diagnostic, treatment, and disposition processes; (4) offer case work services aimed at helping the patient remove fears, prejudices, and social, environmental, and economic problems which may be hindering recovery or performance of duty; and (5) where possible, will offer case work services to the patient's family directed at helping them understand the nature of the patient's problems and how they can most effectively aid him.

#### As a Psychiatric Social Work Officer



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The psychiatric social work officer is responsible for offering, supervising, or administering direct psychiatric case work service to patients in Army hospitals and clinics. In this activity he is employed in a direct working relationship with psychiatrists and the allied scientist as an important member of the neuropsychiatric team.

In addition to serving in Army hospitals and outpatient clinics, the psychiatric social work officer may also serve in mental hygiene consultation services in training divisions, United States disciplinary barracks, reception centers, ports of embarkation, neuropsychiatric hospitals, reconditioning units, convalescent centers, replacement centers, separation centers, and neuropsychiatric combat teams. In these assignments, the psychiatric social work officer will apply case work techniques in the process of selection, rejection, screening, reconditioning, and specialized treatment.

### As a Medical Social Work Officer

The medical social work officer is responsible for providing case work to facilitate the medical officers' early diagnosis and successful treatment of patients attending outpatient clinics, and all hospital patients except those who are the responsibility of the neuropsychiatric service. As he develops professionally, he may also serve as a supervisor or administrator of case work activities.

The medical social work officer explores the patient's situation with the medical officer and the patient to assist the medical officer in identifying the pertinent social factors retarding treatment and to help the patient make effective use of the medical services offered.

### Advantages of Army Social Work

The Social Work Officer participates in a program which insists on high professional standards. The minimum qualification for commissioned service is a Master's Degree in social work from an accredited school. It offers a very rewarding area of practice, an unusually wide variety of assignments, and participation in a program making an important contribution to the defense of a free world.

There is opportunity to teach social work in service schools and opportunity to participate in research projects, including those having for their purpose the improvement of known case work techniques and the development of new ones.

### Who Can Become an Army Social Work Officer

#### Reserve Commissions

All applicants must be at least 21 years of age, loyal citizens of the United States, and meet the prescribed moral and physical standards. Women with dependents under 18 years of age are not eligible unless they have legally surrendered the custody and control of such children.

Men and women who have a Master's Degree in social work from a graduate school offering a 2-year curriculum accredited by the American Association of Schools of Social Work meet the minimum professional qualifications for appointment as social work officers. No prior military service is required.

### How to Apply

#### For appointment in the Medical Service Corps Reserve and Extended Active Duty

Obtain applications for both appointment in the Medical Service Corps Reserve as a social work officer, and for extended active duty (both applications may be submitted at the same time) from the office of your nearest Organized Reserve Corps Senior Instructor, the Headquarters of your Military District, the Headquarters of your Army Area, or write to The Surgeon General, Department of the Army, Washington 25, D. C., Attention: Chief, Personnel Division.

Applications should be forwarded through Reserve channels to the commanding general of the Army Area in which you reside.



# ADMINISTRATIVE SERVICE

## SURGEON GENERAL'S OFFICE COMPLETES HOSPITAL MANAGEMENT WORKSHOP AT FITZSIMONS ARMY HOSPITAL

The Office of the Surgeon General of the Army recently conducted a two weeks workshop at Fitzsimons Army Hospital, Denver, Colorado, to evaluate the progress made during the past year in hospital management improvement. This was the second course of this type to be held.

The first management course of this kind was held at Valley Forge Army Hospital last year for the purpose of indoctrinating a selected group of officers in the new organization and procedures developed at the test hospital. From this group were selected management officers and executive officers for large Army hospitals. During the past year all the Army's large named hospitals in the continental United States have been reorganized according to the new structure as outlined by the Surgeon General. Likewise, new procedures were implemented and local Management Improvement projects were initiated.

The new organization provides many new features but four of them are particularly significant:

1. A management office is established in each hospital as a staff element to assist the Commanding Officer in the execution of the Manpower Control, Fiscal, and Methods Improvement functions.

2. A non-professional, Medical Service Corps officer is provided the Commanding Officer to manage the administrative elements of the hospital with the title of Executive Officer.

3. A Medical Records, Reports, and Tabulating Division is established and equipped with electrical accounting machines to accomplish on a centralized basis all appropriate statistical and accounting operations.

4. A Women's Medical Specialist Corps officer (Dietitian) is assigned the complete responsibility for the management of the Food Service operation. Previously, a male officer was the manager and the dietitian was an advisor.

Continuous tests are in progress at Valley Forge Army Hospital, the Management Research Center for Named Army hospitals. The Camp Atterbury Army Hospital has likewise been designated for projects peculiar to station hospitals. A pilot hospital has been selected in each Army Area to initiate the implementation of the new organization developed for station hospitals.

Those in attendance at the workshop were unanimous in the feeling that a great deal of progress has been made. All those directly engaged in the Management Improvement Program of the Army Medical Service had an opportunity to bring themselves up to date on the over-all program and to exchange views and ideas with their co-workers.

Visitors participating included Mr. F. F. Fitzpatrick, Ford Motor Company; Mrs. Ann S. Friend, American Hospital Association; Mr. Hubert Hughes, Administrator, General Rose Memorial Hospital, Denver, Colorado; Lieutenant Colonel Carl R. Yost, Comptroller of the Army's Office; Colonel D. C. Trendennick and Lieutenant Colonel Earl H. Study, Office of the Assistant Chief of Staff G-4.

(The above article is from Office of the Surgeon General, D/A, Technical Information Office, Washington 25, D. C.)

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More than 7000 medical students were enrolled in Medical Schools during 1950-51 sessions.

The number of licensed physicians in continental United States reached 209,040 as of 15 December 1950.

Report of American Medical Association



## ADMINISTRATIVE SERVICE

### ARMY MEDICAL SERVICE SENDS SCRUB TYPHUS EXPEDITION TO MALAYA

Continuing its fight against scrub typhus, the Army Medical Service will again send a team of doctors and medical research scientists to the Federated Malay States and British North Borneo, to make additional studies and experiments aimed at the eradication of the disease from that area and other parts of the world where it is endemic. The group is scheduled to leave Washington June 15.

Scrub typhus, a fever that proved almost as dangerous to American troops in the Pacific as the enemy during World War II, has long been one of mankind's most baffling diseases. The Army's interest in this disease is two-fold: protection of troops in the event it becomes necessary to send them into infected areas and, from the humanitarian standpoint, improving the health of the native populations.

Knowledge acquired as the result of work done by three similar teams in Malaya during the postwar years has produced specific curatives. In early 1948, such a team, after conducting experiments among its own members and certain groups of infected civilians, under controlled conditions, has reported that the more recently discovered antibiotics proved to be highly effective therapeutic agents in the treatment of scrub typhus. Chloromycetin, aureomycin and terramycin, the drugs of choice in the order named, provide the only known specific treatment for the infection. Prior to their discovery only para-aminobenzoic acid, which was but slightly helpful and not satisfactory was used.

The mission of the present group is to attempt to develop an effective vaccine to prevent the initial infection, and to experiment with impregnated clothing, chemical sprays, and other means of eliminating the mites which carry the disease.

This group will undertake its studies at the invitation of the British and Malay governments. Headquarters will be established in the capital city of Kuala Lumpur and the work will be carried on in collaboration with the British Scrub Typhus Commission, staff members of the Institute for Medical Research, and various Malayan medical groups.

The six officers making up the Army Medical Service team, all from the Medical Service Graduate School of the Army Medical Center at Washington, D. C., are: Major Charles L. Wisseman, Jr., of the Army Medical Center; Major Herbert Ley, Jr., of 2220 Washington Avenue, Silver Spring, Maryland, and First Lieutenant Philip Y. Patterson, of 2212 Colston Drive, Silver Spring, Maryland, all officers in the Medical Corps; Captain Warren G. Hoag, 8217 - 14th Avenue, Hyattsville, Maryland, of the Veterinary Corps; Major Robert Traub, 1207 North Pitt Street, Alexandria, Virginia, and First Lieutenant Fred Diercks, 7029 Strathmore Street, Chevy Chase, Maryland, both of the Medical Service Corps.

An additional member, Dr. David H. Johnson, of the Division of Mammals of the Smithsonian Institute, will leave the unit at British North Borneo where he will conduct studies of the various jungle animals which serve as hosts for the infectious mites. The selection of this location was made necessary because of the hostility of Chinese Communist guerrillas who have made field work in the countryside and jungles of Malaya extremely hazardous. Dr. Johnson will be joined later by Major Traub, field director of the research team, and Major Wisseman after the Malayan program has been organized.

(The above article is from Technical Information Office, Office of the Surgeon General, Department of the Army, Washington 25, D. C.)

#### LINER, TENT, SURGICAL OPERATING TRUCK AND TENT, SECTIONAL HOSPITAL

General.--Recent field exercises indicate that liners coated with pyroxylin constitute a fire hazard and should be salvaged and replaced. It is essential that a 100 percent inspection be made of all liners, tent, surgical operating truck, and liners, tent, sectional, hospital in storage at installations and depots (including stock in separate storage and assemblages), and in the hands of troops. All panels of each liner must be inspected and tested since in many instances different panels of the same liner have been found to contain varying types of treatment.



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## ADMINISTRATIVE SERVICE

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Testing compound.--The following testing compound, to be made available by local purchase, will be used in identifying the pyroxylin treatment:

Solvent formula

Ethyl acetate-	- - - - -	50 percent by volume
Ethyl alcohol-	- - - - -	30 percent by volume
(Denatured)		
Naptha	- - - - -	20 percent by volume

Method of testing.--Place several drops of the mixed solvent on the surface of the coating. Allow to stand for 1 minute and then touch with the finger the area covered by the solvent. If pyroxylin is in the binder of the coating composition, that area will wipe off very readily because the mixture is a good solvent for the same.

Disposition of liners.--Liners found with pyroxylin coating will be salvaged.

Replacements.--Requisitions will be submitted through channels for replacement of Liners, Tent, Sectional only. Tent, Surgical, Operating, Truck and components, has been reclassified as obsolete.

(The above article is from D/A Circular 24, 30 March 1951)

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## DENTAL SERVICE

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### *ARMY REVISES ASSIGNMENT METHODS OF DENTISTS*

Present methods of assignment of dentists in theaters of operations are being revised to provide better professional use of their time, as well as to make all types of dental service more readily available to the troops, the Department of the Army announced today.

Formerly, one dental officer was normally assigned to a battalion and certain other units of about the same size.

Under the new plan, dental officers will be withdrawn from all units smaller than a division. Dental service will be provided by various types of mobile detachments and teams, and dental clinics for all troops in theaters of operations. Assignments of these detachments and teams, which vary in size and type of work, may be made anywhere in a given area in which their services are required.

The change will not affect established hospital and medical facilities of the Army Medical Service in the U. S. or overseas, nor will it affect the established Army-wide ratio of two dentists per thousand troops.

The new plan resulted from studies initiated by the Surgeon General's Office and was designed to provide a more efficient dental service. The prime objective is to make dental treatment more readily available to all troops, rather than exclusively to those units to which dental officers are assigned under the present system. It also assures that dentists will be more fully occupied with their professional duties, and that dental surgeons will have more direct control over the dental service and personnel.

The different types of dental detachments and teams to be used include large dental clinics, mobile and stationary dental prosthetic detachments, service detachments and operating teams.

The largest of these, a fixed dental clinic, has 25 dentists and 42 enlisted men. This unit will provide dental service for large concentrations of troops in theaters of operations.

The smallest detachments, the operating team, will consist of one dentist and one enlisted man, and will be assigned to provide dental service in isolated areas.

(The above article is from Office of the Surgeon General, Technical Information Office, Washington 25, D. C.)



# PREVENTIVE MEDICINE

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## GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations, exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 16).

The non-effective rate\* decreased from the June rate of 14.32 to 12.89 for the month of July. Days lost as a result of disease and injury totaled 10,520 during the four week period ending 25 July 1951.

$$\text{*Non-Effective Rate} = \frac{\text{Total Days lost} \times 1,000}{\text{No. of Days in Period} \times \text{Average Daily Strength}}$$

Non-Effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate\*\* for disease and injury in July was 320.1, compared to 388.2 during June. Total admission for disease and injury in June was 716. Of this number 587 admissions were for disease and 129 injuries. Fort McNair reported the highest admission rate, and U. S. Army Dispensary, The Pentagon reported the lowest rate during the current month.

$$\text{**Admission Rates} = \frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

July's rate for disease cases is 262.4 for 587 cases. Fort McNair reported the highest admission rate, and U. S. Army Dispensary, The Pentagon reported the lowest rate for disease cases.

An injury admission rate of 57.6 per 1,000 per annum for July was reported. This was an increase over the June rate of 56.6. Fort Belvoir reported the highest rate and All Others reported the lowest rate for injuries.

There were no deaths reported during the four week period ending 25 July 1951, by units within the Military District of Washington less Walter Reed Army Hospital.

## COMMUNICABLE DISEASE

Common respiratory diseases decreased in incidence during the month of July 1951. The rate for the present month is 47.8 compared to the June rate of 72.7. Fort McNair reported the highest rate, and Fort Belvoir reported the lowest rate. Admission rates for pneumonia (all types) increased during the July report period. The rate being 16.5 compared with the June rate of 15.6. There were no cases of scarlet fever reported throughout the month of July.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, and hepatitis during the four week period ending 25 July 1951.

Pertinent statistical tables may be found on pages 17, and 21.

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GENERAL DATE  
4-Week Period Ending 25 July 1951  
(Data from DD Forms 442)

(Data from DD Form 442)

STATION	MEAN STRENGTH			DIRECT ADMISSION						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Virginia	17557	15653	1904	453	336.32	357	265.05	96	71.27	13.32	0
Fort McNair, Wash, DC	725	649	76	31	557.36	29	521.05	2	35.96	8.33	0
Fort Myer, Virginia	4249	4101	148	120	368.13	101	309.85	19	58.29	8.91	0
US Army Dispensary The Pentagon	4049	4030	19	59	189.94	51	164.18	8	25.75	18.53	0
All Others	2577	2573	4	53	268.08	49	247.85	4	20.23	8.88	0
Total-Military Dist. of Washington	29157	27006	2151	716	320.10	587	262.43	129	57.67	12.89	0
AMC--Med Det(Duty Pers)	1621	1508	113	88	707.60	83	668.70	5	40.20	28.30	0

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR  
4-Week Period Ending 25 July 1951  
(Data from DD Forms 442)

STATION	Common Respiratory Disease	Pneumonia All Types	Pneumonia Atypical	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Hepatitis	Malaria	Influenza	Psychiatric Disease
Fort Belvoir, Va.	32.67	26.73	17.82	2.23	3.71	-	2.23	2.23	1.48	17.82	1.48	21.53
Fort McNair, Wash DC	161.81	-	-	-	-	-	-	-	-	17.98	-	-
Fort Myer, Virginia	46.02	3.07	3.07	3.07	-	-	-	-	-	3.07	-	-
US Army Dispensary The Pentagon	90.14	-	-	-	-	-	-	-	-	-	-	-
All Others	55.64	-	-	-	-	-	-	-	-	-	-	-
Total - Military Dist/Wash.	47.84	16.54	11.18	1.79	2.68	-	1.34	1.34	.89	11.62	.89	13.41
AMC-Medical Detach. (Duty Pers)	136.70	-	-	-	-	-	-	-	-	-	8.00	-

\* \* \* \* \*

The Surgeon's Office, MDW, participated with distinction in the recently held CPI conducted by Headquarters, MDW, to test the capabilities of the staff in coping with a simulated disaster in the Metropolitan area of Washington. The CPI was held during a continuous 24-hour period, during which the participating services and civilian agencies worked out their specific plans for meeting the situation presented by the umpires. Much valuable experience was gained, and the Surgeon and his staff are now developing plans for future exercises of this type.

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Captain James W. Keenan, MSC, former Executive Officer to the Surgeon, MDW, has recently been transferred to the Office of the Surgeon General, Career Management Division.

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# PREVENTIVE MEDICINE

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## VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington, increased during the July report period.

The rate for July 1951, was 21.01, an increase over the June rate of 16.58. A total of 47 cases reported for the four week period ending 25 July 1951. Of this total 45 were reported by Fort Belvoir and 2 cases for Fort Myer.

During the report period, white personnel incurred 17 of the reported number of cases, with a rate of 8.21 and 30 were incurred by Negro personnel with a resulting rate of 181.80 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (July) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 18, 19, and 20.

### NEW VENEREAL DISEASE CASES - EXCL EPTS - MAY, JUNE AND JULY 1951

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	MAY 1951	JUNE 1951	JULY 1951	JULY 1951
Fort Belvoir	14.76	22.84	33.41	2.563
Fort McNair	-	32.07	-	-
Fort Myer	-	15.43	6.14	.470
US Army Dispensary, Pentagon	-	-	-	-
All Others	-	-	5.06	.388
Total - Military District of Washington Units	8.52	16.58	21.01	1.611
Army Medical Center-Medical and Holding Detachments	-	4.14	11.69	.896
Total - Dept/Army Units Mil Dist/Wash	7.67	15.33	20.05	1.538
	*	*	*	*

### Venereal Disease Statistics

Army-wide venereal disease incidence showed a considerable decline over the previous year. For troops in the United States, venereal disease incidence in 1950 was the lowest recorded since the Army first began collecting medical statistics in 1819. The average daily percentage of Army personnel unavailable for duty because of venereal disease declined from fifteen-hundredths of one percent in 1947 to one one-hundredth of one percent in 1950. In 1948 and 1949 the figures were eight-hundredths of one percent and four-hundredths of one percent respectively.

(The above is extracted from an article "Despite Korea, Expansion, Army's Health is Still Good", from Technical Information Office, Office of the Surgeon General, Department of the Army, Washington 25, DC)

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CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY  
MDW RATE PER 1000 TROOPS PER YEAR

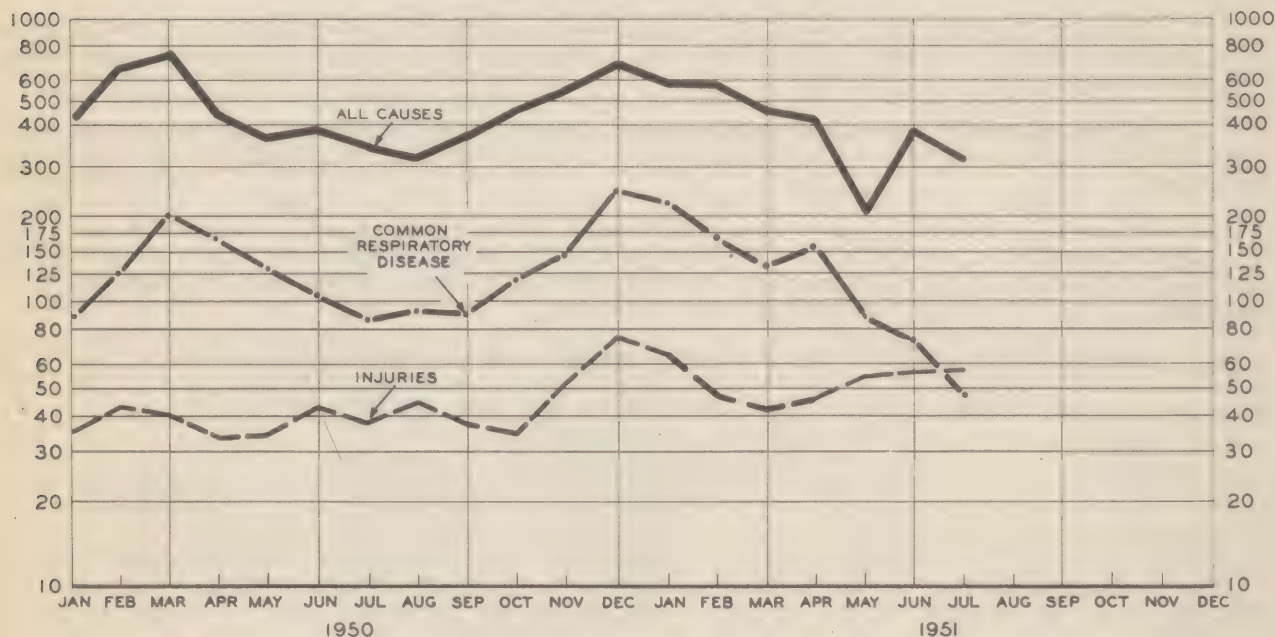
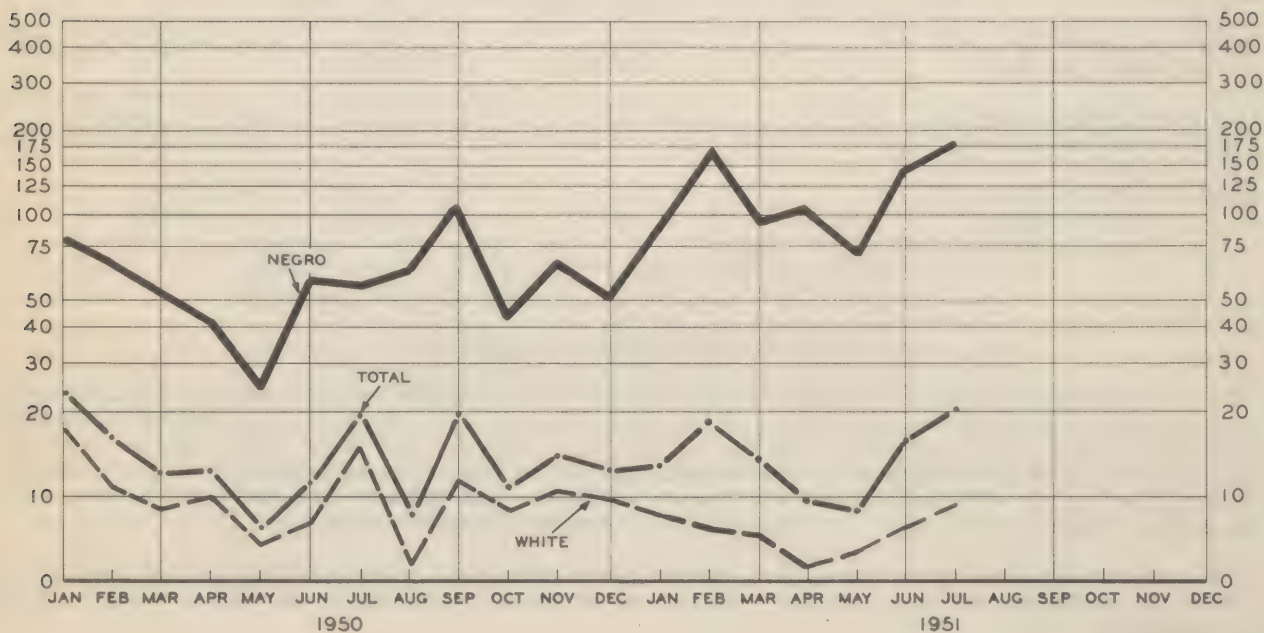


CHART 2

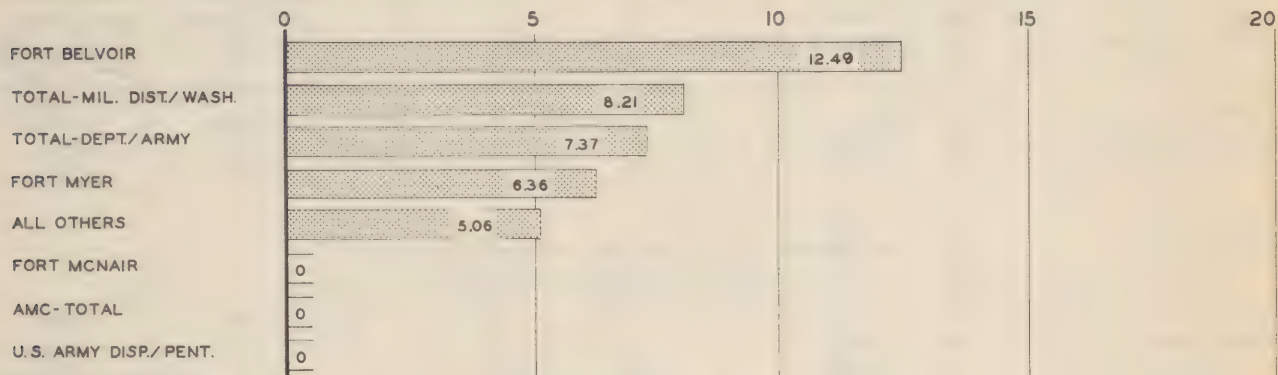
ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER  
RATES PER 1000 TROOPS PER YEAR  
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



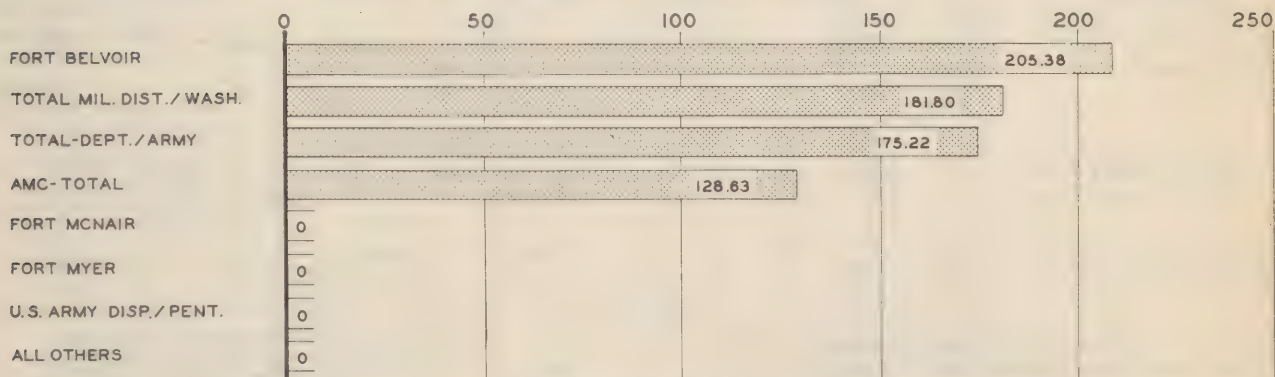
**RESTRICTED**



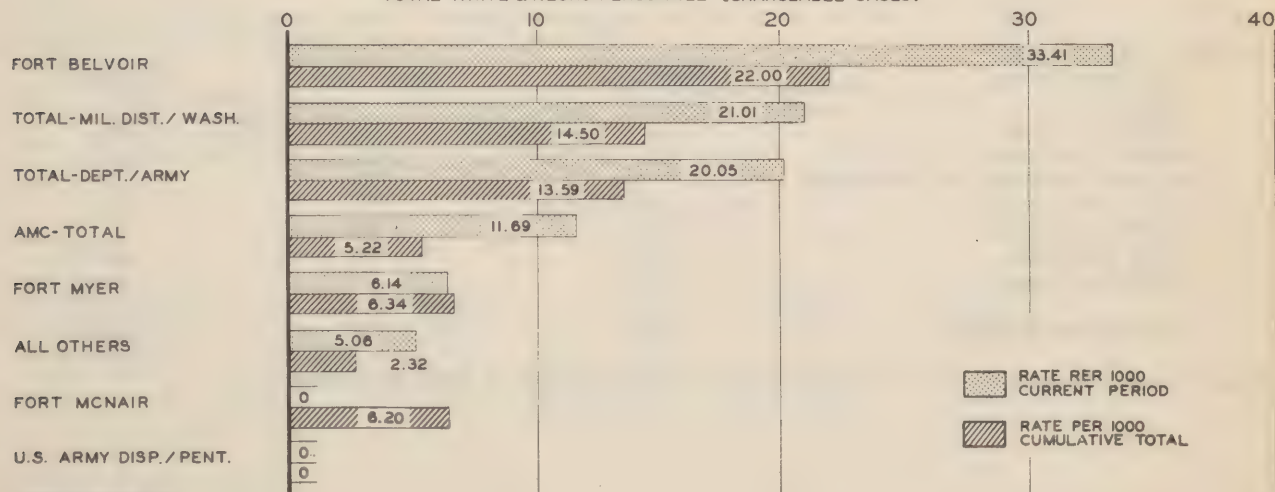
## VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 25 JULY 1951 WHITE PERSONNEL (CHARGEABLE CASES)



## VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 25 JULY 1951 NEGRO PERSONNEL (CHARGEABLE CASES)



## VENEREAL DISEASE RATES PER 1000 PER YEAR FOUR WEEK & CUMULATIVE TOTALS ENDING 25 JULY 1951 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



RATE PER 1000 CURRENT PERIOD  
 RATE PER 1000 CUMULATIVE TOTAL



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CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT  
 For the Four Week Period Ending 25 July 1951  
 (Data from DD Forms 442) (Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
Fort Belvoir	W	15653	2	13	0	15	12.49	.958
	N	1904	5	22	3	30	205.38	15.756
	T	17557	7	35	3	45	33.41	2.563
Fort McNair	W	649	0	0	0	0	-	-
	N	76	0	0	0	0	-	-
	T	725	0	0	0	0	-	-
Fort Myer	W	4101	1	1	0	2	6.36	.487
	N	148	0	0	0	0	-	-
	T	4249	1	1	0	2	6.14	.470
US Army Dispensary The Pentagon	W	4030	0	0	0	0	-	-
	N	19	0	0	0	0	-	-
	T	4049	0	0	0	0	-	-
All Others	W	2573	0	1	0	1	5.06	.388
	N	4	0	0	0	0	-	-
	T	2577	0	1	0	1	5.06	.388
Total-Military District of Washington	W	27006	3	14	0	17	8.21	.629
	N	2151	5	22	3	30	181.80	13.947
	T	29157	8	36	3	47	21.01	1.611
Army Medical Center	W	3041	0	0	0	0	-	-
	N	304	2	1	0	3	128.63	9.869
	T	3345	2	1	0	3	11.69	.896
Total-Dept/Army Units	W	30047	3	14	0	17	7.37	.565
	N	2455	7	23	3	33	175.22	13.441
	T	32502	10	37	3	50	20.05	1.538

VENEREAL DISEASE RATES\*  
 (All Army Troops)

	MAY 1951	JUNE 1951	JULY 1951
First Army Area	15	21	31
Second Army Area	20	22	28
Military District of Washington	8	16	20
Third Army Area	19	30	32
Fourth Army Area	29	48	39
Fifth Army Area	17	19	24
Sixth Army Area	29	30	41
TOTAL United States	21	28	32

\*Compiled in the Office of the Surgeon General and Included US Army Hospitals.

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## PREVENTIVE MEDICINE

## DENTAL SERVICE - FOUR WEEK PERIOD ENDING 25 JULY 1951

STATION	MILITARY		CIVILIAN		Sit- tings	Amal- gam	Oxy and Amal	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures			Ex- trac- tions	Calcu- lus Re- moved	X- Rays	Exam- ina- tions
	Men	Duty Days	Men	Duty Days									Full	Par- tial	Re- pair				
Fort Belvoir	32	862	1	21	8466	2856	1701	762	5	17	13	24	29	65	28	1826	491	2287	1754
Fort McNair	2	51	0	0	212	110	58	22	0	1	0	0	3	4	2	34	0	60	65
Fort Myer, Va.	4	100	1	21	1635	367	106	82	1	1	1	6	5	18	12	147	20	555	348
US Army, Dis- pensary, Pent.	8	211	0	0	1868	528	254	171	5	7	5	6	10	16	19	130	169	801	715
All Others	4	118	0	0	1082	331	102	88	1	0	0	4	7	17	4	239	83	99	636
Total - MDW	50	1342	2	42	13263	4192	2221	1125	12	26	19	40	54	120	65	2376	763	3802	3518

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED 1951  
(Data obtained from WD AGO Form 8-134)

STATION	CLASS* 3	CLASS* 4	CLASS* 5	CLASS* 6	CLASS* 7	CLASS* 8	CLASS* 9	TOTAL
Fort Lesley J. McNair		53,863	141,804		194,267		53,033	442,967
Fort Belvoir, Virginia		649,986	497,404		1,098,004	133,320	436,830	2,815,544
Alexandria Field Buying Office		628,675	101,443	767,103			103,347	1,600,568
Fort Myer, Virginia		162,362	153,328		312,224	15,522	166,603	810,039
Cameron Station, Virginia		160,228	147,789	852	281,591	7,545	110,936	708,941
MDW Veterinary Detachment	1,013,025	26,103						1,039,128
The Pentagon						334,577		334,577
Army Medical Center		186,843	158,171		348,211	14,691	73,009	780,925
TOTAL	1,031,025	1,868,060	1,199,939	767,955	2,234,297	505,655	943,758	8,532,689

## REJECTIONS:

Not Type Class or Grade  
MDW Veterinary Detachment

15,415

15,415

Insanitary or Unsound  
Fort Lesley J. McNair  
Alexandria Field Buying Office  
MDW Veterinary Detachment

42,603

400

350

350

400

42,603

TOTAL

58,018

400

350

58,768

\*Class 3 - Prior to Purchase  
 \*Class 4 - On Delivery at Purchase  
 \*Class 5 - Army Receipt except Purchase  
 \*Class 6 - Prior to Shipment

\*Class 7 - At Issue  
 \*Class 8 - Purchase by Post Exchange, Clubs  
 Messes or Post Restaurants  
 \*Class 9 - Storage

## OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the four-week period ending 25 July 1951.

## ARMY:

Number of Outpatients . . . . . 12508  
 Number of Treatments . . . . . 16334  
 NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED  
 NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED

## NON-ARMY:

Number of Outpatients . . . . . 14121  
 Number of Treatments . . . . . 17125  
 . . . . . 1029  
 . . . . . 14987

## HOSPITAL MESS ADMINISTRATION

STATION	APRIL 1951	MAY 1951	JUNE 1951	JULY 1951
Fort Belvoir				
Income per Ration	\$1.2999	\$1.2996	\$1.3178	\$1.3327
Expense per Ration	1.2716	1.2549	1.2453	1.2586
Gain or Loss	+ .0283	+ .0447	+ .0725	+ .0741

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# CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

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## THE PROMOTION OF THE HEALTH AND EFFECTIVENESS OF THE WORKER

By  
C.E. TURNER, Sc.D., Dr.P.H.

How can we maintain and promote the health of the great group of workers? What factors are involved in the maintenance of those conditions and relations most conducive to vigorous health and effective effort?

A healthful environment, proper arrangement and supervision of work, and healthful living on the part of the worker are all essential. Knowledge or certain phases of health must be possessed by the managerial staff if environment and supervision are to be made right. The health education of the worker determines, in large measure, the healthfulness of his daily regimen.

This objective is a common interest of both management and worker, for it involves carrying on the present work schedule with less physical, mental, and emotional strain; or increasing the effectiveness of the worker with the same contribution of strength and effort.

In any consideration of this problem we must bear in mind the interrelationships of physical, mental, and emotional health. We are concerned with the worker as an individual. His health is affected not only by the physical conditions under which he works, and his muscular fatigue, but also by ennui, boredom, frustrations, zest for work, enjoyment of social contacts, diet, rest, and recreation.

Safeguarding the work place is important. This field of safety is divided into two parts--first, safety engineering, which provides a safe environment; and second, safety education, which seeks to improve the attitudes, habits, and knowledge of the employee. These two aspects are closely interrelated. Much has been said about building safety into the equipment and layout of plants. This will assist materially; however, safety must be built into the organization of foremen and workers, and the fact remains that education is the primary means to this end.

Certain general principles have been established, through past experience, which have contributed to the success of the safety program. Employers and foremen should realize that the devising and adoption of safe working methods are a constant and integral part of their jobs. The support and enthusiasm of the men should be enlisted. The problem should be presented as their problem. Their pride, responsibility for the well-being of others, and the idea of leadership should be appealed to. The program should be so planned and presented that is adjusted to the interests and capabilities of the men-supervisors and workers alike. The positive side of the problem should be presented.

It is obvious that selecting the worker and fitting him to the job is a process which concerns both his health and effectiveness. An outstanding example of the process is to be found in the selection and testing of airplane pilots who must successfully pass a battery of mental and physical tests. In industry neither the required skills nor the hazards are as great. Nevertheless, it is desirable in the interest of employee health to place the worker at tasks to which he is physically and mentally adapted.

The general medical examination is the first bulwark of defense in avoiding employee placement injurious to health. Various tests can be used by the industrial psychologist and physiologist in determining aptitude and capacity. Neither the methods of testing nor the relative values of individual tests can be discussed within present space limitations. The more important types of tests: are mental tests, tests of the efficiency of the neuromuscular system, sensory tests, strength tests, occupational tests and mechanical ability tests.

The want for a feeling of personal worth is one of the most fundamental desires of man. This feeling of personal worth comes largely from satisfactory relationships with one's superior and with one's associates. Unsatisfactory human relationships involving humiliation, anger, fear, and frustration produce the most striking and disastrous effects upon personality, efficiency, and health.

Education in regard to safety and education concerning personal and community health should be made available to the employee in industry. The employee may receive individual instruction in health from the physician, the nurse, or the dentist when he visits the dispensary for examination advice or first aid.

(The above is an extracted article from "Industrial Hygiene", Lanza and Goldberg, Oxford Medical Pub.)

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# CHART OF DRUG USAGE

A simplified chart is presented for ready reference by medical personnel. The drug of choice and alternates are indicated, together with a comparison with the sulfonamides. Except for a few conditions, it will be noted that the antibiotics as a group are the drugs of choice:

Data are listed only for the available and commonly used agents, and are principally based on available clinical experience. The drug of choice listed may be supplanted as further experience accumulates. Combinations of chemotherapeutic agents are not herein presented. Significant variation in susceptibility of strains are present in some instances.

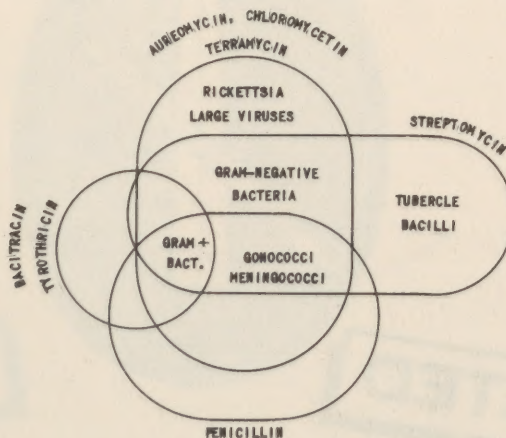
++ - Drug or drugs of choice.

≠ - Weak activity or inconclusive data

+ - Alternative drug.

0 - No significant activity or data available

ORGANISM	PENICILLIN	STREPTOMYCIN	AUREOMYCIN	CHLOROMYCETIN	TERRAMYCIN	SULFONAMIDES
Streptococcus hemolytic	++	≠	++	++	++	++
Streptococcus viridans	++	≠	++	++	++	++
Streptococcus fecalis	++	≠	++	++	++	++
Staphylococcus aureus	++	≠	++	++	++	++
Staphylococcus albus	++	≠	++	++	++	++
Diplococcus pneumoniae	++	≠	++	++	++	++
Clostridium group	++	0	++	++	++	0
Corynebacterium diphtheriae	++	0	++	++	++	0
Bacillus anthracis	++	0	++	?	++	++
Bacillus subtilis (rare in man)	++	++	++	++	++	++
Neisseria gonorrhoeae	++	++	++	++	++	++
Neisseria meningitidis	++	0	++	++	++	++
Hemophilus influenzae	0	++	++	++	++	++
Hemophilus pertussis	0	++	++	++	++	++
Hemophilus ducreyi (chancroid)	0	++	++	++	++	++
Klebsiella pneumoniae (Friedlander's)	0	++	++	++	++	++
Escherichia coli (E-coli)	0	++	++	++	++	++
Aerobacter aerogenes	0	++	++	++	++	++
Proteus vulgaris	0	++	++	++	0	++
Pseudomonas aeruginosa	0	++	≠	++	0	≠
Eberthella typhosa (typhoid fever)	0	0	++	++	++	0
Salmonella group (paratyphoids)	0	0	++	++	++	0
Shigella dysenteriae and group	0	++	++	++	++	++
Pasteurella tularensis	0	++	++	++	++	0
Pasteurella pestis	0	++	++	++	++	≠
Brucella group	0	++	++	++	++	++
Bacterium funduliformis	++	?	++	?	++	?
Streptobacillus moniliformis	++	?	?	?	?	?
Actinomyces bovis	++	0	++	++	++	++
Erysipelothrix rhusiopathiae	++	?	?	?	?	?
Treponema pallidum (syphilis)	++	≠	++	≠	?	0
Treponema pertenue (Yaws)	++	≠	?	?	?	0
Borrelia recurrentis (relapsing)	++	0	++	++	++	0
Spirillum minus (rat bite fever)	++	0	++	?	?	0
Leptospira icterohemorrhagiae	++	?	++	?	?	0
Mycobacterium tuberculosis	0	++	≠	≠	0	++ Sulfones
Mycobacterium leprae	0	++	?	?	0	++ Sulfones
Psittacosis virus	+	0	++	++	++	++
Lymphopatia venereum virus	+	0	++	++	++	+
Prim. atypical pneumonia virus	0	0	++	++	++	0
Donovan body	0	+	++	++	++	0
Rickettsiae (entire group)	0	0	++	++	++	0
Endameba histolytica	≠	0	++	0	++	0
Vibrio comma (cholera)	0	++	++	+	++	0



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